Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOCTOR'S HOSPITAL PO BOX 809053 DALLAS TX 75380	MFDR Tracking #: M4-04-0251-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TRUCK INSURANCE EXCHANGE Box #: 14	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Insurance paid incorrectly should have paid 2040.00 This is an outpatient charges."

Amount in Dispute: $7310.50

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "…it should be noted that the provider incorrectly billed this admission as an outpatient admission when in fact this was an inpatient admission…According to the Provider's UB-92, the Claimant was admitted on October 21, 2002 at 0600 hours (see boxes 17 and 18) and the claimant was discharged on October 22, 2002 at 1600 hours (see boxes 6 and 21). Therefore, the claimant's stay exceeded 23 hours and would be considered an inpatient admission."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/21/2002 through 10/22/2002	N	Inpatient Surgery	$7310.50	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on September 2, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 9, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - N-Not Documented.
   - Paid according to Zurich policy, Medicare guidelines plus 20%. Per RN review specialist, no further payment recommended.
2. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." A review of the submitted medical records supports that the claimant's length of stay exceeded 23 hours; therefore, this admission is an inpatient per Division rule at 28 TAC §134.401(b)(1)(B).

3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401."
4. Division rule at 28 TAC §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118.00."
5. The hospital admission was from 10/21/2002 thru 10/22/2002; therefore, the length of stay was one day.
6. Per Division rule at 28 TAC §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 1 X $1118.00 = $1,118.00. The insurance carrier paid $1,368.00. Therefore, additional reimbursement cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

DECISION:

		10/21/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		10/21/2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.